Advance Care Planning and Goals of Care Communication in Older Adults with Cardiovascular Disease and Multi-Morbidity

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KEYWORDS

• Advance care planning • Goals of care • Patient-doctor relationship
• Communication • Older adults • Cardiovascular disease • Multi-morbidity

KEY POINTS

- Advance care planning (ACP) involves a process of eliciting patients' values and life goals over time and then translating those values into appropriate medical care plans.
- ACP can help individuals receive medical care that is aligned with their values and improve patient-reported outcomes.
- ACP should be initiated early in the disease trajectory for patients with cardiovascular disease, even at the time of diagnosis, and account for how other chronic conditions impact their prognosis, personal values, and medical preferences.
- Multidisciplinary teams can promote ACP by
  - Assessing patients' readiness to engage
  - Asking about surrogate decision-makers
  - Engaging patients in discussions about values and preferences

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INTRODUCTION

Advance care planning (ACP) is relevant for the estimated 85.6 million American adults (>1 in 3) who have cardiovascular disease, including 85% of men and 86% of women older than 80 years.[1] Many of these individuals have more than one chronic condition (ie, multi-morbidity). For example, 86% of patients with heart failure have multi-morbidity, with hypertension, hyperlipidemia, and arrhythmias being common.[2,3] The American Geriatrics Society published guiding principles for the care of older adults with multi-morbidity, emphasizing a person-centered approach that includes patient preferences and current medical conditions.[4] Although the American Heart Association (AHA) emphasized the importance of ACP in heart failure, ACP and goals of care communication should be integrated into the care of all older adults with cardiovascular disease and multi-morbidity.[2]

This article defines ACP, discusses the benefits and challenges to ACP in older adults with cardiovascular disease and multi-morbidity, and provides practical steps for clinicians about assessing patients' readiness to engage in ACP, identifying surrogate decision-makers, and asking about values related to quality of life. The authors also provide practical guidance to documenting patients' preferences, translating these preferences into medical orders, and communicating these preferences with other providers.

What Is Advance Care Planning?

ACP is a process whereby people identify their values and preferences for medical care and designate a surrogate decision-maker in advance of a medical crisis or the loss of decision-making capacity.[5] The goal is to help patients receive medical care that is aligned with their preferences. **Table 1** provides common ACP terms and definitions. It is important to note that ACP includes several behaviors, such as considering treatment goals in light of personal values, completing advance directives, and communicating with families and clinicians[6] (**Fig. 1**). The ACP process may be started at any age and any stage of illness.[7] It may focus on designating a surrogate and discussing preferences for surrogate decision-making (eg, degree of leeway or flexibility when making decisions).[8] It may also focus on discussions about values related to quality of life and preferences for overall health states that patients may or may not find acceptable (eg, being bed bound or in a coma). Ideally, early, anticipatory ACP conversations between patients, surrogate decision-makers, and health care providers will prepare patients and families for in-the-moment goals of care conversations, such as decisions about the use or nonuse of life-sustaining treatments and unanticipated events.[2,8] Therefore, over time, ACP discussions and documentation may focus on specific goals of care for medical treatments, such as cardiopulmonary resuscitation (CPR) or the implantation of a left ventricular assist device (LVAD).[5,9]

The importance of focusing ACP on values identification and ongoing discussions, and not just a one-time documented advance directive, cannot be overstated.[10] Completing advance directive documents is only one part of ACP (see **Fig. 1**). Living wills often focus on preferences for life-sustaining procedures, such as CPR and mechanical ventilation in specific medical situations. As patients' clinical condition changes over time, their preferences and values may also change. Furthermore, in addition to CPR, patients and their loved ones may need to make many decisions that are not addressed in advance directives, such as whether to have pacemaker and/or implantable cardioverter defibrillator (ICD) placement; cardiac catheterization; advanced cardiac therapies, such as inotropes or LVADs; or nursing home placement. Values-focused discussions can help patients, surrogates, and clinicians with all the